

BREAST ASSESSMENT REFERRAL FORM

Please complete all sections and fax to 519-646-6201

St. Joseph's use only:	BA Mammo	Right	Left	Bilat	Exam date: _____
	BA Ultrasound	Right	Left	Bilat	
	Other:				

1. PATIENT INFORMATION – please affix label or complete:

Last Name: _____
 First Name: _____ Middle initial: _____
 Preferred name: _____ Pronouns: _____
 Birth Sex: Female Intersex Male Prefer not to disclose
 Date of birth: _____ / _____ / _____
Year Month Day
 Health Card No.: _____ VC: _____
 Address: _____
 City: _____ Postal Code: _____
 Phone: _____ alternate tel.: _____
 Email: _____
 Long-Term Care resident No Yes: _____

2. REFERRING PHYSICIAN INFORMATION

Referring physician: _____
 Address: _____
 City: _____ Postal Code: _____
 Billing No.: _____
 Phone: _____
 Fax: _____
 Family physician: _____
**** Screening for patients aged 40 to 74 years with no symptoms and no previous breast cancer: patient can self-schedule OBSP appointment at www.sjhc.london.on.ca/book-breast-screening or call (519) 646-6105 ****

Mobility: Ambulatory Wheelchair Stretcher Mechanical lift
Interpreter required? No Yes, language: _____
Pregnant? No Yes, how many months: _____
Breastfeeding? No Yes, how many months: _____

3. PREVIOUS IMAGING done outside of St. Joseph's? No Yes

If yes, when? _____
 Where? _____

4. REASON FOR REFERRAL

Patient history of breast cancer? No Yes
 Does the patient have breast implants? No Yes
 If yes, indicate type: Silicone Saline

Appointment for:

- Non-OBSP SCREENING****
 BI-RADS 3
 New Clinical Concern

5. New clinical findings:

	Right	Left	
Palpable lump			Lump detected by: <input type="checkbox"/> Patient <input type="checkbox"/> Physician
Pain			<input type="checkbox"/> Focal <input type="checkbox"/> Diffuse <input type="checkbox"/> Intermittent
Nipple discharge <i>(only if spontaneous, non-milky)</i>			Type of discharge <input type="checkbox"/> Bloody <input type="checkbox"/> Other:

Description: _____

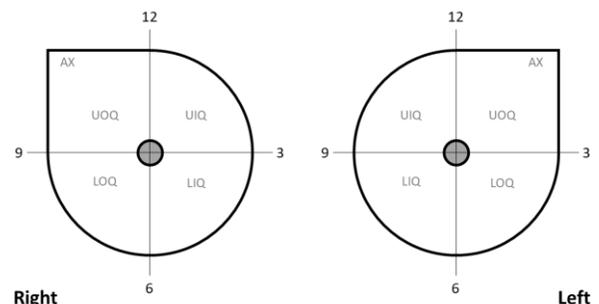
6. Patient Screen for Serum Creatinine

History of impaired renal function or nephrectomy? No Yes
 Taking medications or has conditions predisposing to nephrotoxicity? No Yes
 Allergy to radiographic contrast? No Yes

If YES to any of the questions in section 6, please provide serum creatinine (must be drawn within the past 3 months):

Result: _____ eGFR: _____ Sample date: _____

7. Please indicate all clinical concerns on diagram



8. NOTE: By signing this requisition, you are providing authorization to St. Joseph's for your patient to receive additional imaging and urgent surgical consultation, as required, to resolve this diagnostic request.

9. Physician signature: _____